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8403 Colesville Road, Suite 860, Silver Spring, Maryland 20910-9813
301-295-7234 • (800) 863-3263 • mcilwain@email.afip.osd.mil • http://www.afip.mil

LAPAROSCOPIC CHOLECYSTECTOMY

BY PAUL J. CONNORS, M.D., J.D., CAPT, MC, USNR

By 1992, approximately 15,000 surgeons had received some form of laparoscopic cholecystectomy (LC) training. Few judicial opinions involving laparoscopic cholecystectomy have been reported, but the general categories of probable allegations are clear. One allegation will be that the surgeon in question should never have performed the procedure. This type of allegation can impose liability on the surgeon and the health care organization. Detail of the surgeon's laboratory experiences, the specifics of the certification of competence, the history of assisting others and being assisted in performing the procedure and the hospital's practices and procedures will be scrutinized. Another form of allegation will be that the surgery undertaken was negligently performed. Evidence will include the nature of the injury, the findings during later treatments, the results of autopsy, and videotapes of the procedure. Allegations premised upon a lack of informed consent can be expected. Courts have generally voiced a desire that patients be adequately informed of the "material" risks, benefits, and alternatives. Minimally, the risks associated with the procedure's learning curve are undeniably material. A significant amount of time will need to pass before sufficient data is available to substantiate a conclusion that LC malpractice claims have replaced open cholecystecomy (OC) cases in frequency or severity or both.

LAPAROSCOPIC CHOLECYSTECTOMY: A DOD STUDY

BY GEORGIA A. MARTIN, R.N., J.D., PH.D.

Within the military health service system, 8,560 cholecystectomies were performed from July 1990 through May 1992. Of these, 2,918 were open procedures and 5,607 were laparoscopic cholecystecomy (LC) procedures.

The frequency of complications from LC was 6.9 percent. The Army, Air Force and Navy complication rates were 6.4 percent, 6.5 percent, and 8.0 percent, respectively. The complications were identified as either severe or non-severe . The Army, Air Force and Navy rates of severe complications were 2.6 percent, 3.0 percent, and 2.7 percent, respectively. The reasons for converting LC to open procedures were divided into four categories: preoperative conditions (e.g., adhesions, aberrant anatomy), intraoperative events (e.g., bleeding), suspected bile duct injury, and specific technical difficulties (e.g., inadequate visualization, difficult trocar placement). Laparoscopic procedures were converted to open procedures in 8.1 percent of cases. The average hospital stay for patients undergoing LC was 3.7 days, compared to 8.2 days for converted procedures. When the DoD cost for a "general surgery day" ($1,070) is applied, the average cost for LC cases was $3,959, and the average cost for cases converted to open procedure was $8,774. The converted cases cost DoD $4,815 more per case and almost $2.2 million. These findings parallel data reported in the literature.

MEDICAL RECORDS

BY DOROTHY RASINSKI, M.D., J.D.

In any malpractice trial, the most important evidence presented to the court is the medical record. Entries in the record should demonstrate the physician's education, training and experience. Frivolous comments, use of the vernacular, frequent sprinkling of meaningless abbreviations, or statements of moral judgement are inappropriate. A medical record should: (1) establish the most likely cause of the patient's problem, (2) support the diagnosis, (3) outline the treatment and management of the patient's condition, and (4) describe the patient's response to treatment or the provider's subsequent action.

Before performing a procedure, obtain and adequately document the patient's informed consent. The record should reveal that the patient was informed of the diagnosis, the contemplated procedure, its indications, associated risks, complications or side effects, the goal to be achieved, the reasonably available alternatives, the expected outcome if nothing is done, and that the patient understood and agreed to the treatment after having been provided the opportunity to ask questions.

Six categories of information should be provided in a medical record: (1) a complete history with a description of the present ailment or injury, recorded in the patient's words; (2) the report of a physical examination revealing objective findings regarding subjective complaints and including significant negatives; (3) a record of diagnostic tests and all similar reports received; (4) an impression or a diagnosis; (5) a record of treatment, medications prescribed, and procedures

recommended or performed; and (6) the patient's response to treatment along with any indicated alterations in the treatment plan.

Keeping carefully prepared, complete, accurate, legible, and timely medical records is a legal obligation, an inherent component of sound medical practice, and one that can afford the provider a nearly impregnable defense against a claim of negligence.

PEDIATRIC BACTERIAL MENINGITIS

BY ALAN R. FIGELMAN, COL, MC, USAR, ET AL

Medical malpractice claims that involve treatable meningitis can be unusually expensive in money and in time. The Department of Defense database of closed malpractice claims contains 26 cases involving pediatric bacterial meningitis. Of 12 paid claims, the mean amount was $661,000. One patient was eight years old, while the others were three years old or younger. Of 13 cases, five involved Group B streptococcus, four involved *Hemophilus influenzae*, and *Streptococcus pneumoniae*.

Practice Tips: Listen to parents carefully. A friendly attitude encourages parents to convey pertinent history and avoids misunderstandings and confrontations. Value differences between health care providers and parents strongly influence the clinical assessment of a febrile child. Pursue consultation when necessary. Provide the parents written instructions. Make sure they understand the seriousness of fever; how to give fluids and treatments; the symptoms that denote clinical worsening; the need to call or return if worsening appears; and when the child is scheduled for reevaluation.

The medical record of a febrile child should clearly reflect that the diagnosis of bacterial meningitis was a consideration. Subjective factors like vomiting, feeding, fluids, irritability, activity, and consolability should be addressed. Objective findings like fever, vital signs, mental status, appearance, activity, and neurologic function should be recorded along with the results of diagnostic studies, consultations, and treatments.

Strep pneumococcal nasopharyngeal isolates are becoming increasingly resistant to penicillin. Currently, oral therapy offers some protection against occult bacteremia caused by strep pneumococcus, while intramuscular antibiotics are required when Hib bacteremia is suspected. True clinical success will continue to remain dependent, however, upon the skilled provider comprehensively evaluating the febrile child and diligently considering whether serious bacterial infection or meningitis could be present.

LEGAL DUTIES INVOLVING THIRD PARTIES: PART TWO

BY DAVID T. ARMITAGE, M.D, J.D., COL, MC,USA

Tatiana Tarasoff was killed by Prosenjit Poddar, a University of California student who was romantically obsessed with her. Poddar was evaluated by a Student Health Service psychiatrist who referred him for outpatient psychotherapy. During psychotherapy, Poddar related that he might kill Tarasoff. The psychiatrist and psychologist conferred and agreed that Poddar should be hospitalized. The campus police interviewed the patient and determined that he was behaving normally and rationally. Poddar subsequently killed Tarasoff. Tarasoff's parents sued the University of California and the professionals. They alleged a negligent failure to hospitalize Poddar and a "failure to notify" them that their daughter was in grave danger. The California Supreme Court held that "[w]hen a doctor or psychotherapist, in the exercise of his professional skill and knowledge, determines, or should determine, that a warning is essential to avert danger rising from the medical or psychological condition of his patient, he incurs a legal obligation to give that warning." In 1976, the court modified its 1974 duty to warn, subsuming it under a broader duty to protect. The court noted that the duty to protect might be discharged in various ways, such as issuing a warning to the intended victim, notifying police, or initiating "steps reasonably necessary under the circumstances." The court declared that any unreliability in prediction does not negate a duty to protect. It considered the risk of unnecessary warnings a reasonable cost for saving potential victims.

Currently, at least ten states have enacted specific statutes that address the duty to warn third parties about a behaviorally dangerous patient. Generally, these laws immunize the provider from liability for a breach of confidentiality. The laws differ with regard to who owes the duty to protect, the type of threats that give rise to the duty, the identifiability of the victim, and the

manner or criteria by which the duty is discharged. Most of these statutes impose a duty on psychologists, psychiatrists, nurses, social workers and professional counselors. Uniformly, the laws require that there be an utterance or some behavior that constitutes a threat of physical violence to another individual. Some require that the threat be "serious", the violence "imminent", or "specific means" for bringing about the injury be communicated. The standard for victim identification ranges from "reasonably identifiable" (most states) to "clearly identified." However, there is little consensus about the most effective manner in which to protect them. As a result, mental health providers can be potentially held liable by a system that can be both arbitrary and unfair.

THE ACUTE RED EYE
BY WILLIAM C. LLOYD, LTC (P), MC, USA

One common ocular complaint is the acute red eye. All providers should be familiar with techniques involved in performing a basic screening eye examination. No single piece of information is more valuable than visual acuity. Without a recorded visual acuity there is no clinical baseline against which to measure vision on follow-up. In addition, patients may claim that the initial vision was anywhere between 20/20 and ***total blindness***.

Tips: If the patient normally wears spectacles to drive, they should be worn when vision is tested. Without glasses, visual acuity can be tested with a pinhole occluder or an index card fenestrated with multiple small holes. Measure one eye at a time, right eye first by convention. Note in the chart if the patient was using the full spectacle correction, a pinhole, or no correction.

The history can be reduced to a few questions, "Are you having the problem in one or both eyes?" or "What were you doing when you first noticed the symptoms?" Discriminate between eye **pain**, **discomfort**, **discharge**, or an asymptomatic **injected globe**. Pertinent facts to note in the record include prior eye conditions and treatments, ocular medications, family eye history, recent trauma, the patient's general medical condition, and use of contact lenses.

Next, perform an external, gadget-free examination. Symmetry is fundamental. Palpate for preauricular and cervical adenopathy. Evert the lower eyelids to examine the tarsal conjunctiva. True bacterial conjunctivitis (frequently bilateral) produces a copious, thick, purulent discharge, while other pathogens cause more watery or stringy exudates. Eversion of the upper eyelid is essential in searching for foreign bodies. Most patients complaining of acute eye pain have irritated corneal nerves. Provide temporary relief with a single drop of topical anesthetic. Apply fluorescein to the cornea and illuminate the surface with a cobalt blue light to highlight epithelial defects. Select these cases carefully. Immediate ophthalmological consultation is obligatory in some acute red eye situations: hyphema, intraocular foreign bodies, and any suspected or confirmed penetrating injury of the globe. An eye shield and prompt referral are recommended. During transfer, the penetrated globe should receive no topical medications, especially ointments.

The majority of red eye cases satisfactorily recover in a few days. Universal follow-up instructions should include discussion of four Ps: **P**ain that increases or is not relieved with aspirin or acetaminophen; **P**us; **P**ink progressive or persistent globe hyperemia; and, **P**oor vision. If the eye does not begin to feel better, look better, and see better, it's time for another exam.

MISDIAGNOSES INVOLVING PREGNANCY
BY FRANK T. FLANNERY, M.D., J.D., COL, MC, USA

The failure to diagnose pregnancy and the inaccurate estimation of gestational age continue to spawn litigation. The Supreme Court of Mississippi considered the case of a 34-year-old woman who presented to her physician with urinary frequency, back pain, and a five-month cessation of menses. Tetracycline and Bactrim DS™ were prescribed. Several weeks later, the patient complained of pelvic tenderness. Diagnosed with a vaginal infection, she was prescribed Flagyl®. Subsequently, she experienced severe abdominal cramping and delivered a stillborn infant. The patient sued, claiming that her physician failed to perform an adequate physical examination resulting in the prescription of teratogenic medication and her unborn child's death. The court reversed an initial summary judgment for the defendant and remanded the case for further disposition.

Failure to detect an ectopic pregnancy also continues to result in professional liability claims. In a recent

case, a patient with an intrauterine device experienced prolonged menstrual bleeding and discomfort. After removing the device, her doctor prescribed antibiotics for a presumptive diagnosis of pelvic inflammatory disease. The results of a subsequent serum pregnancy test were positive, and a sonogram demonstrated a small uterine lucency suggesting an early gestation. Three weeks later, the patient was hospitalized for a ruptured right tubal pregnancy. The patient sued, claiming a failure to diagnose the ectopic pregnancy. An initial verdict against the defendant was overturned on appeal because the plaintiff's expert had never practiced obstetrics or gynecology.

Finally, successful suit can be brought for failure to accurately calculate gestational age. In one case, a woman stopped taking oral contraceptive medication in late January and visited her physician in March. He estimated that conception had occurred in December. The physician induced labor the following October. A five pound, nine ounce infant was born with respiratory distress syndrome and was placed on a respirator. A pneumothorax developed and insertion of a chest tube was required. The parents sued, alleging a negligent calculation of gestational age that resulted in injury to the premature infant. A trial verdict for the plaintiffs was affirmed on appeal.

Provider oversight and the vagaries of clinical medicine still lead to failures in diagnosing and staging pregnancy. A high index of suspicion and proper utilization of diagnostic tests remain crucial in limiting liability.

VETERANS AFFAIRS ANALYSIS OF MEDICAL MALPRACTICE CLAIMS FY 1993 REPORT BY RICHARD L. GRANVILLE, M.D., J.D., ET AL

In 1992, the Department of Legal Medicine (DLM), Armed Forces Institute of Pathology (AFIP), began collecting VA medical malpractice data. More than half the cases were surgery or treatment related, and medication cases accounted for 12.8 %. A total of 997 specialties were listed for 752 claims. The most frequently reported specialty was internal medicine with 13.1%; general surgery, 8.7%; psychiatry, 7.4%; orthopedic surgery, 6.7%; and nursing, 5.4%.

A total of 1,276 allegations of negligence were entered for 752 claims. Treatment cases comprised 30% of the negligence codes. Diagnosis cases accounted for 23.2%, surgery cases accounted for 21.1%, and medication cases accounted for 13%. Medical and surgical services, with 31.1% and 27.8% respectively, were the most frequently represented hospital services. In nearly half, the injury occurred either in the patient's room or in the operating suite. In another 17%, the injury occurred in the out-patient area. A total of 1,321 providers were named in 653 cases. Staff physicians comprised 61%; physicians in training, 32.8%. A total of 1,048 presenting symptoms were identified in 501 cases. The most frequent presenting symptoms were: chest pain, 48 cases; joint pain or stiffness, 41 cases; abdominal pain, 38 cases; and general weakness, 37 cases. The organ system involved was identified in 501 cases. The two systems most frequently involved were the circulatory system with 90 cases, and the musculoskeletal system with 85 cases.

As new trends in medical malpractice are recognized researchers are encouraged to arrange specific studies.

To obtain the full text including references, literature and case law review, and valuable clinical practice tips worth 5 CME credits, follow the instructions under the Editor's Notes on page 1.